

IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF NEW YORK

L.T. *et al.*,

Plaintiffs,

-against-

HOWARD A. ZUCKER, in his official capacity and in his
individual capacity,

Defendant.

DECLARATION

1:21-CV-1034 (LEK/DJS)

**DECLARATION OF
JOHANNE E. MORNE**

STATE OF NEW YORK)
COUNTY OF ALBANY) ss.:

JOHANNE E. MORNE, declares under penalty of perjury, pursuant to 28 U.S.C. §
1746, that the following is true:

1) I am the Deputy Director for Community Health, New York State Department of Health (“Department” or “DOH”) Office of Public Health. In this role, I serve as the Director for both the AIDS Institute and the Center for Community Health. As such, I am responsible for directing state programs, services and activities relating to HIV/AIDS, sexually transmitted diseases (“STDs”), hepatitis C, drug user health, and LGBT health. Additionally, I oversee chronic disease prevention, epidemiology, nutrition, and family health services. I have been the Deputy Director since July 2021 and was previously the Director of the AIDS Institute beginning in 2016 and the Director of Office Planning and Policy at the AIDS Institute beginning in 2010.

2) I have a Master of Science in Education and Counseling as well as a Bachelor of Arts in both Psychology and Social Work from the College of St. Rose in Albany, New York.

3) During the COVID response, I have served as Acting Deputy Director for the Office of Public Health. I responded initially to the pandemic when Glen Island, New York was

declared a containment area to establish policies and set up testing infrastructure. I have overseen the teams that conducted antibody testing, cluster response, and school reopening. Additionally, I have overseen the Department's role in the mass vaccination sites across the state.

4) I am familiar with the facts set forth herein based upon personal knowledge, discussions with Department staff, and Department records. I have also reviewed guidance from the Centers for Disease Control & Prevention ("CDC") and the State, executive orders issued by the Governor, as well as studies and publications related to COVID-19.

5) I make this affidavit in opposition to Plaintiff's Verified Petition.

The Emergency Rule on School Masking

6) The Department and the Commissioner of Health ("Commissioner") are charged with the overarching responsibility to protect the public health pursuant to Public Health Law ("PHL") §§ 201 and 206. Specifically, pursuant to PHL § 201(1)(m), the Department "shall ... supervise and regulate the sanitary aspects ... businesses and activities affecting public health." Pursuant to PHL § 206, the Commissioner "shall ... take cognizance of the interests of health and life of the people of the state, and of all matters pertaining thereto." These statutes obligate the Department and the Commissioner to take action when the public health is put at risk by an unprecedented and unpredictable global pandemic, and the rapid outbreak of severe and fatal respiratory illnesses associated therewith.

7) The New York State Administrative Procedure Act ("SAPA") § 202(6)(a) provides: "Notice of emergency adoption. (a) Notwithstanding any other provision of law, if an agency finds that the immediate adoption of a rule is necessary for the preservation of the public health, safety or general welfare and that compliance with the requirements of subdivision one of

this section would be contrary to the public interest, the agency may dispense with all or part of such requirements and adopt the rule on an emergency basis” (emphasis added).

8) The broad standard under SAPA recognizes that emergencies can take innumerable forms, most of which cannot be predicted.

9) The Department and the Public Health and Health Planning Council (“PHHPC”) have utilized their authority under SAPA in recent years to promulgate emergency regulations.

Examples include:

- a) Lead testing in school drinking water (NY Reg, Sept. 21, 2016 at 14-17; 10 NYCRR Subpart 67-4) that aimed to prevent children from being exposed to lead;
 - b) Requiring standards for operation of “cooling towers” that can harbor legionella bacteria and spread disease (NY Reg, Sept. 2, 2015 at 14-17; 10 NYCRR Part 4);
 - c) Creating civil penalties for possession of “bath salts” and synthetic marijuana (NY Reg, Aug. 26, 2015 at 8-11; 10 NYCRR Subpart 9-1);
 - d) Requiring local health departments to develop action plans to address the potential spread of the Zika virus (NY Reg, Apr. 6, 2016 at 23-24; 10 NYCRR § 40-2.24);
 - e) Facilitating the prescribing and dispensing of controlled substances, administering treatment for narcotics addiction, and creating an opioid overdose program (NY Reg, Aug. 27, 2014 at 11-13, and Oct. 18, 2017 at 16-17; 10 NYCRR §§ 80.136 and 80.138).
- 10) The Emergency Rule at issue in the present matter, which provides the

Commissioner with discretion to issue mask or face-covering requirements in certain settings, was adopted by PHHPC on July 29, 2021. Due to new, pertinent information related to the prevalence of the predominant COVID-19 variant in New York, minor modifications were made to the regulatory section and emergency justification after it was adopted by PHHPC. These changes were presented to PHHPC on August 26, 2021 and approved by the Commissioner and filed with the Secretary of State on August 27, 2021. A copy of the Emergency Rule is attached hereto as **Exhibit A**.

11) In accordance with SAPA § 202(6)(b), the Emergency Rule went into effect immediately upon filing. In accordance with SAPA § 202, emergency regulations are effective for 90 days, subject to renewal.

12) The Emergency Rule was promulgated pursuant to the authority vested in PHHPC and the Commissioner by PHL § 225. PHHPC is authorized by § 225 to establish, amend, and repeal sanitary regulations to be known as the State Sanitary Code (“SSC”), subject to the approval of the Commissioner.

13) PHL § 225(5)(a) provides that the SSC may deal with any matter affecting the security of life and health of the people of the State of New York. PHL § 225(4) authorizes PHHPC, in conjunction with the Commissioner, to protect public health and safety by amending the SSC to address issues that affect life and health, or the preservation or improvement of public health.

14) This Emergency Rule was adopted based on rational determinations by the Department and PHHPC that it was necessary to immediately address an ongoing and rapidly worsening public health crisis. The Department has accumulated, compiled, and analyzed data and

research regarding the nature and progression of COVID-19, its communicable nature, and particularly the emergence of the Delta variant. These considerations provided a rational basis for the promulgation of the regulation in question on an emergency basis and the Department complied with SAPA in doing so.

15) Namely, despite the ending of the state disaster emergency on June 24, 2021, “[w]ith the emergence of the Delta variant, a strain twice as transmissible as the SARS-CoV-2 strain, this does not mean that COVID-19 is gone. Cases have risen 10-fold since early July, with the Delta variant accounting for 95% of recent sequenced positives in New York State.” See Exhibit A.

16) “[T]hese regulations update previously filed emergency regulations to provide that masking may be required under certain circumstances, as determined by the Commissioner based on COVID-19 incidence and prevalence, as well as any other public health and/or clinical risk factors related to COVID-19 disease spread.” Id.

Updated Department COVID-19 Guidance Related to Schools

17) On June 7, 2021, Governor Cuomo “announced that school districts can choose to lift the requirement that their students must wear masks outdoors. Guidance on mask use indoors remains in place.” A copy of Governor Cuomo’s press announcement dated June 7, 2021, is attached hereto as **Exhibit B.**

18) The next week, on June 15, 2021, Governor Cuomo announced that “COVID-19 restrictions are lifted immediately as 70 percent of New Yorkers aged 18 or older have received the first dose of their COVID-19 vaccination series.” Governor Cuomo lifted all State mandated COVID-19 restrictions, except for the mask requirement for unvaccinated individuals and the

mask requirements and “health guidelines [that] continue to be in effect for large-scale indoor event venues, pre-K to grade 12 schools, public transit, homeless shelters, correctional facilities, nursing homes, and health care settings, per [current] CDC guidelines.” A copy of the June 15, 2021 Press Release, “Governor Cuomo Announces COVID-19 Restrictions Lifted as 70% of Adult New Yorkers Have Received First Dose of COVID-19 Vaccine” is attached hereto as **Exhibit C**.

19) Governor Cuomo ended the state disaster emergency to fight COVID-19 on June 24, 2021, citing declining hospitalization and positivity statewide, as well as success in vaccination rates. A copy of the June 23, 2021 Press Release” is attached hereto as **Exhibit D**.

20) However, “with the emergence of the Delta variant, a strain twice as transmissible as the SARS-CoV-2 strain, this does not mean that COVID-19 is gone.” See Exhibit A.

21) With the state disaster emergency ended but with the continuing need to control the spread of the prevalent Delta variant, Commissioner Zucker “recommend[ed] following guidance from the CDC and local health departments.” A copy of the August 5, 2021 Press Release “Statement from New York State Department of Health Commissioner Dr. Howard Zucker” is attached hereto as **Exhibit E**.

22) The New York State Education Department issued a Health and Safety Guide for the 2021-2022 School Year on August 12, 2021. A copy of the August 12, 2021 Press Release “State Education Department Issues Health and Safety Guide to Reopen New York State Schools” is attached hereto as **Exhibit F**. The guide notes that “due to emerging evidence that demonstrates that the Delta variant of COVID-19, currently the predominant strain in the United States, is more infectious and has led to increased transmissibility when compared to other variants” both “**the CDC and the American Academy of Pediatrics [“AAP”] recommend universal indoor**

masking for all teachers, staff, students, and visitors to K-12 schools, regardless of vaccination status and community transmission levels.” (emphasis in original). A copy of the Health and Safety Guide for the 2021-2022 School Year is attached hereto as **Exhibit G**.

23) On August 24, 2021, Governor Hochul announced a change to the mask requirement for schools due to the rising COVID-19 cases caused by the Delta variant. The Governor “directed the New York State Department of Health to institute a universal mask requirement in all schools, public and private, as determined necessary at the discretion of the Commissioner.” This was to be accomplished “through regulatory action established by [PHHPC].” See supra ¶ 10. A copy of the August 24, 2021 Press Release “On First Day in Office, Governor Hochul Announces Comprehensive Plan to Help Ensure a Safe, Productive Return to Schools This Fall” is attached hereto as **Exhibit H**.

24) Commissioner Zucker stated that “[s]ince early July, COVID-19 cases in New York have risen 10-fold and 95 percent of sequenced positive cases were confirmed to be Delta variant. Based on incidence and prevalence, our findings demonstrate the necessity of layered prevention strategies, including this mask requirement. While a simple measure of prevention, requiring masks now is crucial for protecting the health of our children and ensuring we can get our students back in their schools this fall.” Id.

25) On August 27, 2021, this emergency regulation was filed with the Secretary of State, see supra ¶ 10, and the Commissioner simultaneously issued a determination on indoor masking. A copy of the August 27, 2021 Commissioner’s Determination on Indoor Masking Pursuant to 10 NYCRR 2.60 is attached hereto as **Exhibit I**. The determination noted that “certain settings and areas [including schools] pose increased challenges and urgency for controlling the

spread of this disease because of the vulnerable populations served, the disproportionate percentage of individuals (e.g., children) who are not yet eligible for the COVID-19 vaccination, and/or the substantial to high levels of community transmission.” Id.

26) Persons under 18, who make up almost the entirety of the Pre-K through grade 12 student population, have a much lower vaccination rate than those over 18.¹ Children ages 12-15 were just recently made eligible to receive the COVID-19 vaccine for emergency use on May 12, 2021, and children under age 12 are not yet eligible.

27) The determination further noted that “as reported by the CDC, research supports that there are no significant health effects or changes in oxygen or carbon dioxide levels from mask wear” and “adopt[ed] [CDC recommendations for face coverings/masks in school settings], imposing them as requirements.” See Exhibit I.

28) On September 2, 2021, the Department issued Interim Guidance for P-12 schools for the 2021-2022 academic year. The Interim Guidance “addresses the minimum expectations for classroom instruction in P-12 schools” and “provides an operational framework for schools to fulfill their primary purpose of educating children during the COVID-19 pandemic” while also “align[ing] with international and national experts” in “adhering to multiple mitigation strategies that include vaccination, the appropriate use of face masks, physical distancing and screening testing to monitor transmission and inform local public health actions.” A copy of the September 2, 2021 Interim NYSDOH Guidance for Classroom Instruction in P-12 Schools During the 2021-2022 Academic Year is attached hereto as **Exhibit J.**

¹ See <https://covid19vaccine.health.ny.gov/vaccine-demographic-data> (last viewed September 28, 2021).

29) On September 15, 2021, Governor Hochul announced a series of additional universal mask requirements given the rise of the Delta variant, with the goal of advancing protections for unvaccinated children. This includes masking requirements for “licensed and registered child care centers, home-based group family and family child care programs, after-school child care programs, and enrolled legally exempt group programs during operational hours.” These new requirements “will provide consistency between child care programs and school children, many of whom often share the same buildings.” They “ensure that children in our child care facilities receive the same protection as children in our schools.” Finally “[t]he new mask requirement in child care facilities brings New York State into compliance with federal [CDC] guidance issued in July that recommends universal indoor masking for anyone age two and older who has not been vaccinated and is medically able to wear a mask. Masking requirements were also extended to “certified residential and day programs, inpatient and outpatient mental health facilities, substance abuse programs, juvenile detention programs, juvenile residential facilities, congregate foster care programs, runaway and homeless youth, domestic violence and other shelter programs.” A copy of Governor Hochul’s Press Release dated September 15, 2021 is attached hereto as **Exhibit K**.

COVID-19 Variants Continue to Present a Grave Threat to Health and Safety

30) Despite the gains that New York has made, the pandemic is not over as numbers have continued to increase. The COVID-19 variants discovered in New York and around the world create an increased risk for transmission and exacerbate the danger in situations that are already considered risky by their nature.

31) The CDC conducts surveillance on SARS-CoV-2 strains to create a library of the various specimens and sequences to better assist in the public health response.² A copy of the CDC Scientific Brief: *Emerging SARS-CoV-2 Variants* is attached hereto as **Exhibit L**. Some notable emerging variants were discovered in the United Kingdom (Alpha), South Africa (Beta), and Brazil (Gamma), all of which spread easier than the original virus. Id. The current predominant variant in the United States is the Delta variant, which is more than twice as transmissible as these previous variants. A copy of the CDC's *Delta Variant: What We Know About the Science* is attached hereto as **Exhibit M**.

32) Alarming, for adolescents and children the CDC found that “[d]uring a subsequent 6-week period after the Delta variant became predominant, rates rose each week to 1.4 during the week ending August 14, 2021, which was 4.7 times the rate during the week ending June 26, 2021 and approached the peak hospitalization rate of 1.5 observed during the week ending January 9, 2021.” A copy of the CDC's Morbidity and Mortality Weekly Report *Hospitalizations Associated with COVID-19 Among Children and Adolescents – COVID-NET, 14 States, March 1, 2020 – August 14, 2021* is attached hereto as **Exhibit N**.

33) More recently, the CDC analyzed new COVID-19 cases emergency department visits and hospital admissions related to COVID-19 among those aged 0-17 years for the period of August 1, 2020 to August 27, 2021. The CDC found that since Delta became the predominant variant in July 2021, the rate of new COVID-19 cases and emergency department visits increased for children and adolescents between 0-17 years. During this two-week period, COVID-19 related

² On May 31, 2021, The World Health Organization (“WHO”) announced new naming labels for the variants of interest and concern. See *Tracking SARS-CoV-2 Variants*, World Health Organization, found at <https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/> (last viewed September 28, 2021).

Emergency Department visits and hospital admissions in states with the lowest vaccination coverage were 3.4 and 3.7 times, respectively, that in states with the highest vaccination coverage. A copy of the CDC's Morbidity and Mortality Weekly Report *Trends in COVID-19 Cases, Emergency Department Visits, and Hospital Admissions Among Children and Adolescents Aged 0-17 Years – United States, August 2020-August 2021* is attached hereto as **Exhibit O**.

34) Additionally, for the week ending September 2, 2021, the AAP reported “children were 26.8% of reported weekly COVID-19 cases,” despite the fact that “[s]ince the pandemic began, children represented 15.1% of total cumulated cases” – a marked increase of 10% in the cumulated number of child COVID-19 cases that occurred over just two weeks, from August 19 to September 2. A copy of the AAP's *Children and COVID-19: State-Level Data Report* dated September 2, 2021 is attached hereto as **Exhibit P**. In fact, “child cases have increased exponentially, with over 750,000 cases added between August 5 and September 2.” Id.

35) For the week ending September 9, 2021, the AAP reported that these numbers increased “exponentially.” The AAP reported that “children were 28.9% of reported weekly COVID-19 cases.” The new AAP report found that as of September 9, “nearly 5.3 million children have tested positive for COVID-19 since the onset of the pandemic. Over 243,200 cases were added the past week, the second highest number of child cases in a week since the pandemic began.” The AAP noted that “[a]fter declining in early summer, child cases have increased exponentially, with nearly 500,000 cases in the past 2 weeks.” A copy of the AAP's *Children and COVID-19: State-Level Data Report* dated September 9, 2021 is attached hereto as **Exhibit Q**. The *Summary of Findings* is attached hereto as **Exhibit R**.

36) All of the predominant named COVID-19 variants have been found in New York; however, in July 2021, every new case except one that was genome sequenced by scientists at the University of Buffalo was the Delta variant, despite the fact that only 1% of cases were Delta in May 2021. A copy of Local Buffalo News article, *Every case except one was delta: NY scientists urge vaccines, masking as delta variant rages* is attached hereto as **Exhibit S**. The CDC variant proportions tracker for the region that includes New York, New Jersey, Puerto Rico, and the Virgin Islands indicates that for the week of September 5 to September 11, 2021, 99.4% of cases were Delta.³ Based on data collected for a 4-week period up to August 28, 2021, in New York State, 97.8% of cases were Delta.⁴

37) Globally, scientists are seeking to understand the ease of the variants' transmission and the efficacy of existing vaccines against them. Id. A great deal of new information about the variants' "virologic, epidemiologic, and clinical characteristics" is developing. See Exhibit L.

38) According to the CDC, the Delta variant is more than two times more contagious than previous variants and may cause more severe illness than previous variants in unvaccinated people. A copy of the CDC's *Delta Variant: What We Know About the Science* is attached hereto as **Exhibit T**. "[D]ata show fully vaccinated persons are less likely than unvaccinated persons to acquire SARS-CoV-2, and infections with the Delta variant in fully vaccinated persons are associated with less severe clinical outcomes." A copy of the CDC's *COVID-19 Vaccines and Vaccination* is attached hereto as **Exhibit U**. Although vaccinated people can become infected and have the potential to spread the virus to others, they do so at much lower rates than

³ See Variant Proportions, CDC, found at <https://covid.cdc.gov/covid-data-tracker/#variant-proportions> (last viewed September 28, 2021).

⁴ Id.

unvaccinated people. Id.; See Exhibit T. SARS-CoV-2 transmission between unvaccinated persons is the primary cause of continued spread. Id. Each of these effects can increase the risk of transmission presented by certain activities that by their nature require individuals to disregard certain protective measures; i.e., masking and distancing.

39) Additionally, all of the abovementioned variants have been characterized by the CDC as variants of concern. A “variant of concern” is one “for which there is evidence of an increase in transmissibility, more severe disease (e.g., increase hospitalizations or deaths), significant reduction in neutralization by antibodies generated during previous infection or vaccination, reduced effectiveness of treatments or vaccines, or diagnostic detection failures.” A copy of the CDC’s *SARS-CoV-2 Variant Classifications and Definitions* is attached hereto as **Exhibit V.**

40) One of the key concerns in this regard is to ensure that New York State does not return to the infection levels experienced during spring of 2020 when the hospitals were overwhelmed, which can lead to further unnecessary deaths. During the spring of 2020, many doctors and nurses came to help New York, as it had become the epicenter for the pandemic. As the entire nation has now, at one point or another, faced high infection rates, New York can no longer rely on the reserve of the additional volunteers.

41) On September 28, 2021, Johns Hopkins reported that globally, 232,596,485 individuals to date had tested positive for COVID-19, and a total of 4,760,783 confirmed COVID-19 deaths worldwide.⁵ In addition, 43,179,771 individuals in the United States had tested positive

⁵ See COVID-19 Dashboard, John Hopkins University of Medicine, found at <https://coronavirus.jhu.edu/map.html> (last viewed September 28, 2021).

for COVID-19 to date, and total 691,706 had died of COVID-19. Id.

42) The first surge of COVID-19 in New York was March-April-May 2020 and a resurgence of the COVID-19 pandemic swept through New York in November-December-January 2020-2021, with previous variants. Now we are in the midst of another resurgence, presently with the highly transmittable Delta variant.

43) New York experienced dramatically rising rates from September through December 2020. For example, on September 1, 2020, 88,447 people were tested for COVID-19 in New York State, with a total of 708 individuals testing positive – a positivity rate of 0.8%. On December 1, 2020, 193,551 were tested for COVID-19, with a total of 8,973 testing positive – a positivity rate of 4.64%.⁶

44) While the rates remained at higher levels through most of winter 2020-2021, as well as briefly in mid-spring, they were trending downward. They began to fall towards the end of April and May, 2021, until June 13, 2021, when a low of 0.35% positivity occurred. Since then, cases have again begun steadily increasing due to the Delta variant. For example, on September 28, 2021, 190,260 were tested for COVID-19, with a total of 5,137 testing positive. This is a total positivity rate of 2.7%.⁷

45) The statewide trends will continue to be monitored to ensure the State is proportionately addressing the risks to public health of the current variants and ensure restrictions are implemented or lifted, as best fits the current facts. It is critical that when restrictions begin to

⁶ See NYSDOH COVID-19 Tracker, Daily Totals: Persons Tested and Persons Tested Positive, found at <https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCovid-19Tracker-DailyTracker?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n> (last viewed September 30, 2021).

⁷ Id.

lift, they are reduced slowly, and the data is monitored for any surges in positive cases that could result from reopening too fast.

46) Consistent with guidance issued by the CDC and WHO, the restrictions in the Emergency Rule, directives, and guidance issued pursuant to the rule are developed with the goal of rapidly addressing COVID-19 outbreaks in the affected areas in order to mitigate risk to the public and reduce the opportunity for the virus to spread.

47) In New York, looking at testing data as of September 28, 2021, the total number of individuals to date who had tested positive for COVID-19 was 2,402,256,⁸ and the number of individuals who had died of COVID-19 was 44,510.⁹

48) The COVID-19 positivity rate has only gone up between the time PHHPC initially passed the emergency regulation on July 29, 2021 and when it was filed on August 26, 2021. For example, on July 29, 2021, in New York State 108,797 individuals were tested for COVID-19, and 2,677 tested positive. Id. This equals a positivity rate of 2.46%. However, on August 26, 2021, 174,812 individuals were tested for COVID-19 and 6,348 tested positive, for a positivity rate of 3.63%. Id. By comparison, on August 26, 2020, 83,437 individuals were tested for COVID and only 791 tested positive, for a positivity rate of .95%. Id. Despite the gains that New York has made, the pandemic is not over as numbers have continued to increase.

49) While at certain times during the pandemic children may have been less likely to

⁸ See NYSDOH COVID-19 Tracker, found at <https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Map?%253Aembed=yes&%253Atoolbar=no&%3AisGuestRedirectFromVizportal=y&%3Aembed=y> (last viewed September 30, 2021).

⁹ See NYSDOH, COVID-19 Tracker, Fatalities by County, <https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%253Aembed=yes&%253Atoolbar=no&%3AisGuestRedirectFromVizportal=y&%3Aembed=y> (last viewed September 30, 2021).

contract and spread COVID-19, adolescents and children are still at risk for both contracting and spreading COVID-19, and as data regarding the predominant Delta variant shows, this risk is currently increasing, see supra ¶¶ 32-35.

Routes of COVID-19 Transmission

50) “Transmission of SARS-CoV-2 can occur through direct, indirect, or close contact with infected people through infected secretions such as saliva and respiratory secretions or their respiratory droplets, which are expelled when an infected person coughs, sneezes, talks or sings.” A copy of the WHO Scientific Brief: *Transmission of SARS-CoV-2: Implications for Infection Prevention Precautions* is attached hereto as **Exhibit W**. “WHO, together with the scientific community, has been actively discussing and evaluating whether SARS-CoV-2 may also spread through aerosols in the absence of aerosol generating procedures, particularly in indoor settings with poor ventilation.” Id.

51) In October 2020, the WHO updated their guidance to confirm that SARS-CoV-2 can spread through aerosol transmission: “[t]he virus can spread from an infected person’s mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe heavily. These liquid particles are different sizes, ranging from larger ‘respiratory droplets’ to smaller ‘aerosols.’” A copy of the WHO’s Question and Answer Page regarding *Coronavirus Disease (COVID-19): How is it Transmitted?* is attached hereto as **Exhibit X**. On October 5, 2020, the CDC also released updated COVID-19 guidance to include information about how the COVID-19 virus can spread through airborne transmission. A copy of the CDC Media Statement on Updates to *How COVID is Spread* is attached hereto as **Exhibit Y**.

52) “People release respiratory fluids during exhalation (e.g., quiet breathing, speaking,

singing, exercise, coughing, sneezing) in the form of droplets across a spectrum of sizes. These droplets carry virus and transmit infection.” A copy of the CDC Scientific Brief: *SARS-CoV-2 Transmission* is attached hereto as **Exhibit Z**. “The smallest very fine droplets, and aerosol particles formed when these fine droplets rapidly dry, are small enough that they can remain suspending in the air for minutes to hours.” Id.

53) COVID-19 has an incubation period of up to fourteen days. A copy of the CDC’s Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) is attached hereto as **Exhibit AA**. Many individuals infected with the COVID-19 virus are asymptomatic but can transmit the virus to others. Id.

Layers of Mitigation and the Importance of Masking

54) The Department follows the CDC guidance, which “recommends universal indoor masking regardless of vaccination status at all levels of community transmission” for K-12 schools. A copy of the CDC Guidance for COVID-19 Preparation in K-12 Schools is attached hereto as **Exhibit BB**.

55) The guidance “emphasizes implementing layered prevention strategies (e.g., using multiple prevention strategies together consistently) to protect students, teachers, staff, visitors, and other members of their households and support in-person learning.” Id. Specifically, “[t]o reduce the risk of becoming infected with the Delta variant and spreading it to others, students, teachers, and school staff should continue to use layered prevention strategies including universal masking in schools.” Id.

56) Additionally, promoting vaccination among all eligible students, staff, and household members “is the most critical strategy to help schools safely resume full operations,”

while physical distancing, screening testing, ventilation, proper cleaning, and isolation and quarantine add to the mitigation layers to prevent transmission of the virus. Id.

57) Masks are an important means to prevent COVID-19 transmission. A copy of the Proceedings of the National Academy of Sciences' ("PNAS") *Identifying Airborne Transmission as the Dominant Route for the Spread of COVID-19* is attached hereto as **Exhibit CC**.

58) While "mask mandates have generated controversy" and "opponents of mask mandates have even sued state governments to block them," "numerous scientific studies confirm that the simple act of wearing masks in public can significantly slow its spread." A copy of The Hill article, *Mask Mandates are Constitutionally Permissible*, dated July 31, 2020, is attached hereto as **Exhibit DD**.

59) The Food and Drug Administration ("FDA") issued the August 5, 2020 Emergency Use Authorization ("EUA") in response to concerns regarding insufficient supply and availability of disposable, single-use surgical masks for use in healthcare settings by health care personnel. This EUA simply authorizes the "emergency use of surgical masks that meet certain performance requirements for use in healthcare settings by health care personnel as personal protective equipment." This EUA is limited to the use of the authorized *surgical* masks in healthcare settings by healthcare personnel, during a time of mask shortages and does not apply to the general use of facemasks outside of a surgical setting. The EUA does not otherwise restrict or have any bearing on mask use outside of hospital settings for general use by the public. A copy of the FDA's August 5, 2020 EUA is attached hereto as **Exhibit EE**.

60) A November 2020 study performed during a time of relatively low community transmission states that "[t]he findings . . . should not be used to conclude that a recommendation

for everyone to wear masks in the community would not be effective in reducing SARS-CoV-2 infections, because the trial did not test the role of masks in source control of SARS-CoV-2 infection,” (i.e. use of a mask by a potentially infectious person) and “[r]eduction in release of virus from infected persons into the environment may be the mechanism for mitigation of transmission in communities where mask use is common or mandated.” This study states that it “was not designed to determine the effectiveness of source control” and “potential benefits of a community-wide recommendation to wear masks include combined prevention and source control for symptomatic and asymptomatic persons.” Finally, “[t]he most important limitation is that the findings are inconclusive” and the study “cannot definitively exclude a 46% reduction to a 23% increase in infection of mask wearers.” A copy of *Effectiveness of Adding a Mask Recommendation to Other Public Health Measures to Prevent SARS-CoV-2 Infection in Danish Mask Wearers* is attached hereto as **Exhibit FF**.

61) The *New England Journal of Medicine* that studied the transmission rates of COVID-19 among U.S. Marine Corps made no findings that masks did not reduce or prevent the spread of SARS-CoV-2. A copy of *SARS-CoV-2 Transmission among Marine Recruits during Quarantine* is attached hereto as **Exhibit GG**.

62) A statement from the WHO from June 2020 Interim Guidance that there is no direct evidence on the effectiveness of mask wearing for healthy people to prevent the spread of COVID-19 did not change WHO’s ultimate conclusion that “to prevent COVID-19 transmission effectively in areas of community transmission, governments should encourage the general public to wear masks in specific situations and settings as part of a comprehensive approach to suppress SARS-CoV-2 transmission.” A copy of the WHO’s *Advice on the Use of Masks in the Context of COVID-*

19 is attached hereto as **Exhibit HH**. Additionally, statements from as early as December 2020 from the WHO are consistent in that they all clearly endorse the use of masks “as part of a comprehensive strategy of measures to suppress transmission and save lives” including children. A copy of the WHO’s *Coronavirus Disease (COVID-19) Advice for the Public: When and How to Use Masks* is attached hereto as **Exhibit II**. A copy of the WHO’s *Coronavirus Disease (COVID-19): Children and Masks* is attached hereto as **Exhibit JJ**.

63) There have been several studies that have demonstrated a significant beneficial effect from masking in reducing COVID-19 case numbers.

64) The “CDC recommends community use of masks, specifically non-valved multilayer cloth masks, to prevent transmission of SARS-CoV-2. Masks are primarily intended to reduce the emission of virus-laden droplets (“source control”), which is especially relevant for asymptomatic or presymptomatic infected wearers who feel well and may be unaware of their infectiousness to others, and who are estimated to account for more than 50% of transmissions.” A copy of the CDC Scientific Brief: *Community Use of Cloth Masks to Control the Spread of SARS-CoV-2* is attached hereto as **Exhibit KK**.

65) “Masks also help reduce inhalation of these droplets by the wearer (‘filtration for personal protection’). The community benefit of masking for SARS-CoV-2 control is due to the combination of these effects; individual prevention benefit increases with increasing numbers of people using masks consistently and correctly.” Id.

66) “Multi-layer cloth masks block release of exhaled respiratory particles into the environment, along with the microorganisms these particles carry. Cloth masks not only effectively block most large droplets (i.e., 20-30 microns and larger) but they can also block the

exhalation of fine droplets and particles (also often referred to as aerosols) smaller than 10 microns; which increase in number with the volume of speech and specific types of phonation. Multi-layer cloth masks can both block up to 50-70% of these fine droplets and particles and limit the forward spread of those that are not captured.” Id.

67) An article published January 2021 in the PNAS entitled *An Evidence Review of Face Masks Against COVID-19* acknowledges that there are many practical limitations on studying the effectiveness of masking with regard to COVID-19 transmission. First, one cannot expect there to be direct epidemiological evidence from controlled trials during a pandemic, due to logistical and ethical reasons. However, this article took stock of all of the studies conducted to date on face masks and COVID-19 transmission and concluded that “population-level compliance with public mask wearing of 70% combined with contact tracking would be critical to halt epidemic growth. Population-level uptake of an intervention to benefit the whole population is similar to vaccinations.” Laws mandating as such are “effective at increasing compliance and slowing the spread of COVID-19.” A copy of Howard *et al.*’s *An Evidence Review of Face Masks against COVID-19* is attached hereto as **Exhibit LL**.

68) Additionally, “[r]esearch supports that mask wearing has no significant adverse health effects for wearers.” Id. There is no reported change “in oxygen or carbon dioxide levels while wearing a cloth or surgical mask either during rest or physical activity” and “mask use was safe even during exercise” with “no physiologic differences [] identified between periods of rest or exercise while masked or non-masked.” Id. See **Exhibit KK**.

69) Claims that masking can lead to bacterial infections that develop into pneumonia, citing a 2008 study by Anthony Fauci, are specious. This is a viral social media claim that has

already been put to rest. This study concluded that a majority of the deaths during the 1918-1919 influenza pandemic likely resulted from secondary bacterial pneumonia. However, this study actually never mentions masks, nor draws the suggested correlation between mask use and the bacterial pneumonia. A copy of USA Today's *Fact Check: Dr. Anthony Fauci did not Say Masks Contributed to Spanish Flue Deaths* is attached hereto as **Exhibit MM**.

70) The study C. Raina MacIntyre et al., *A cluster randomised trial of cloth masks compared with medical masks in healthcare workers*, 5 British Medical Journal e006577 (2015), which evaluated cloth masks as PPE for health care workers and purports that cloth masks are not recommended due to the increased risk of infection for wearers is frequently misinterpreted. This study "compared a 'surgical mask' group, which received two new masks per day, to a 'cloth mask' group that received five masks for the entire 4-wk period and were required to wear the masks all day, to a 'control group,' which used masks in compliance with existing hospital protocols." See **Exhibit LL**. In this study, there was no control group which did not wear masks because it was "deemed unethical". Id.

71) The recently published article in PNAS, *An Evidence Review of Face Masks Against COVID-19* argued that "[t]he study does not inform policy pertaining to public mask wearing as compared to the absence of masks in a community setting. They found that the group with a regular supply of new surgical masks each day had significantly lower infection of rhinovirus than the group that wore a limited supply of cloth masks, consistent with other studies that wore a limited supply of cloth masks, consistent with other studies that show surgical masks provide poor filtration for rhinovirus, compared to seasonal coronaviruses." See **Exhibit LL**.

72) The myth that wearing a cloth face mask will lead to a bacterial or fungal infection has been discredited. While bacteria can collect on masks, they pose no risk as long as masks are cleaned regularly. A copy of UnityPoint Health's *Expert Sets Straight 5 Common Face Mask Myths* is attached hereto as **Exhibit NN**.

73) While many have challenged the use of masks for children by claiming ill effects on their ability to breathe, these claims have been largely debunked. A review of at least two studies on children using N95 masks found no significant effect on the ability to breathe. A copy of Eberhart, M., Orthaber, S., and Kerbl, R. (2021) *The impact of face masks on children – A mini review* is attached hereto as **Exhibit OO**. A review on these studies found that “[t]he few existing studies suggested that surgical and cloth masks did not significantly compromise ventilation and oxygen supplies in healthy individuals and may, therefore, be considered as not harmful.” Id.

74) Another study published in March 2021 found that “use of surgical masks among children was not associated with episodes of oxygen desaturation or the development of clinical signs of respiratory distress during a walking test.” A copy of Lubrano *et al.*'s *Assessment of Respiratory Function in Infants and Young Children Wearing Face Masks During the COVID-19 Pandemic* is attached hereto as **Exhibit PP**.

75) Additionally, in accordance with the Commissioner's determination issued pursuant to 10 NYCRR 2.60 and the September 2, 2021 Interim Guidance the Department issued for P-12 schools for the 2021-2022 academic year, people with “medical or developmental conditions that prevent them from wearing a mask may be exempted from mask requirements, as documented by a medical provider.” This is further subject to CDC-recommended exceptions. See Exhibits I, J. The CDC has noted exceptions for people who cannot wear a mask because of

a disability as defined by the Americans with Disabilities Act, 42 U.S.C. 12101 *et seq.* A copy of the CDC’s Guidance for COVID-19 Prevention in K-12 Schools is attached hereto as **Exhibit QQ**. However, the CDC has noted that while certain groups of people may find it difficult to wear a mask, including those with underlying medical conditions, most people with underlying medical conditions can and should wear masks, including those with asthma. A copy of the CDC’s *Considerations for Wearing Masks* is attached hereto as **Exhibit RR**.

COVID-19 Impact on Schools

76) Reopening schools and the instructional model used by each school district (in-person learning, remote, hybrid) has always ultimately been a local decision. While the State set the general parameters for schools reopening and recommended the prioritization of in-person learning, local school districts made the determination as to whether to reopen to in-person instruction within these parameters. Department guidance from August 2020 spoke to these parameters, such as social distancing of 6 ft in all directions **or** the use of appropriate physical barriers, among other things.” A copy of the August 26, 2020 Reopening New York, *Summary Guidelines for In-Person Instruction at Pre-K to Grade 12 Schools* is attached hereto as **Exhibit SS**.

77) Initially, the Department issued extensive and detailed guidance, checklists, and toolkits for “all types of public and private (both secular and non-secular) elementary (including pre-kindergarten), middle, and high schools authorized to provide in-person instruction.” A copy of the June 7, 2021 Interim Guidance for In-Person Instruction at Pre-K to Grade 12 Schools During the COVID-19 Public Health Emergency is attached hereto as **Exhibit TT**. The guidance

served as a roadmap for school districts to establish their own reopening plans in accordance with the Department's Master Guidance. Id.

78) On July 9, 2021, the CDC replaced its K-12 operational strategy with a new guidance because “with COVID-19 cases increasing nationally since mid-June 2021, driven by the [Delta variant], protection against exposure remains essential in school settings.” See Exhibit QQ. The new guidance was updated to add information related to promoting COVID-19 vaccination, align with guidance for fully vaccinated people, and emphasize the COVID-19 prevention strategies most important for in-person learning, among other things. Id. On August 4, 2021, the guidance was again updated to “recommend universal masking for all students, staff, teachers, and visitors to K-12 schools, regardless of vaccination status” due to “the circulating and highly contagious Delta variant.” Id.

79) The CDC “emphasizes implementing layered prevention strategies (e.g., using multiple prevention strategies together) to protect students, teachers, staff, and other members of their households, and to support in-person learning. This guidance is based on current scientific evidence and lessons learned from schools implementing COVID-19 prevention strategies.” Id. The CDC also provides information on what people should know about the importance of mask wearing and their effectiveness. See Exhibit RR. See also, CDC's *Help Stop the Spread of COVID-19 in Children* which is attached hereto as **Exhibit UU.**

80) “While fewer children have been sick with COVID-19 compared to adults, children can be infected with the virus that causes COVID-19, can get sick from COVID-19, and can spread the virus that causes COVID-19 to others. Children, like adults, who have COVID-19 but have no symptoms (‘asymptomatic’) can still spread the virus to others.” A copy of the CDC's *COVID-*

19 in Children and Teens is attached hereto as **Exhibit VV**. Students can bring home the virus and unknowingly spread it to parents and/or grandparents.

81) Additionally, it is important for schools providing in-person instruction to consider “associations between levels of community transmission and risk of transmission in school.” A copy of CDC’s *Scientific Brief: Transmission of SARS-CoV-2 in K-12 Schools* is attached hereto as **Exhibit WW**.

82) Schools have closed due to COVID-19 outbreaks resulting from the fact that “[s]ignificant secondary transmission of SARS-CoV-2 infection can and does occur in school settings when prevention strategies are not implemented or are not followed. When outbreaks occur in school settings, they tend to result in increased transmission among teachers and school staff rather than among students.” Id.

83) For example, “[i]n Israel, high schools were closed less than two weeks after reopening when two symptomatic students attended in-person learning, leading to 153 cases among students and 25 among staff members, from among 1,161 students and 151 staff members tested. Importantly, prevention strategies were not adhered to – including lifting of a mask requirement because of a heat wave and classroom crowding.” Id.

84) Children are not spared from potential devastating affects. While “[m]ost children with COVID-19 have mild symptoms or have no symptoms at all [], some children can get severely ill from COVID-19. They might require hospitalization, intensive care, or a ventilator to help them breathe. In rare cases, they might die.” See Exhibit VV.

85) The Department is also well aware of concerns of mental health issues during the pandemic, and previous guidance provided that schools must have “[a]vailable resources and

referrals to address mental health, behavioral, and emotional needs of students, faculty, and staff when school reopens for in-person instruction (e.g., how they will identify and support students having difficulty with transitioning back into the school setting, especially given the changed school environment). Any training for faculty and staff on how to talk with, and support, students during and after the ongoing COVID-19 public health emergency, as well as information on developing coping and resilience skills for students, faculty, and staff.” See Exhibit TT.

86) The ultimate priority is to minimize risk of COVID-19 transmission to safely allow for in-person instruction for children and to prevent further outbreaks that might necessitate school closures. UNICEF has stated that “no effort should be spared to keep schools open or prioritize them in reopening plans.” A copy of UNICEF’s Report: *COVID-19 and School Closures: One Year of Education Disruption* is attached hereto as **Exhibit XX**. It is now understood that school closures are extremely disruptive to children’s education and well-being. Id. UNICEF and the WHO recommend the “use of masks in in the school setting” in order to keep schools open. A copy of UNICEF and the WHO’s *Considerations for school-related public health measures in the context of COVID-19* is attached hereto as **Exhibit YY**.

87) The AAP also “strongly advocates that all policy considerations for school COVID-19 plans should start with a goal of keeping students safe and physically present in school” and accordingly recommends universal masking, as it is “the best and most effective strategy to create consistent messages, expectations, enforcement, and compliance without the added burden of needing to monitor vaccination status” for students who are eligible. A copy of the AAP’s *COVID-19 Guidance for Safe Schools* is attached hereto as **Exhibit ZZ**. AAP also recommends masking

due to “continued concerns for variants that are more easily spread among children, adolescents, and adults.” Id.

88) The ABC Science Collaborative, which is funded through the National Institutes of Health (“NIH”), found that “[p]roper masking is the most effective mitigation strategy to prevent COVID-19 transmission in schools when vaccination is unavailable or there are insufficient levels of vaccination among students and staff.” A copy of the ABC Science Collaborative’s *The ABCs of North Carolina’s Plan A* is attached hereto as **Exhibit AAA**. “With masking in place, Plan A – full, in-person instruction – is appropriate for all grades and all schools.” Id.

89) These findings were based on a study of over one million students. Id. Further, eight additional studies in seven states support these findings, with all of them determining that schools with universal masking policies had extremely low within-school transmission during the 2020-2021 school year. See Exhibits BBB - III.¹⁰

90) Two studies published by the CDC suggest that face-mask requirements in schools drastically reduce the spread of Covid-19 among children.¹¹ In an Arizona study, researchers looked at two of the state’s most populous counties, where students started in-person learning in late July and early August. The study tracked which schools required students and staff to wear masks indoors and which ones did not, and noted when those mask mandates were implemented, at the beginning of the school year or sometime after classes began. **Exhibit JJJ.**

¹⁰ Two of the additional studies also took place in North Carolina, see Exhibits BBB and CCC, and one additional study each took place in Utah, Missouri, Georgia, Wisconsin, Virginia, and California. See Exhibits DDD - III, respectively.

¹¹ <https://www.wsj.com/articles/schools-with-face-mask-requirements-had-fewer-covid-19-outbreaks-cdc-study-finds-11632515562?mod=mhp>; Masks in school help prevent Covid-19 outbreaks and spread, CDC studies find - CNN.

91) The database where all school-associated outbreaks in the state are reported showed 191 school outbreaks between July and August. Around 8% of these outbreaks were in schools that implemented early masking requirements, 33% were in schools that required masking later on, and just over 59% were in schools without masking requirements. The study showed that schools without mask requirements were 3.5 times more likely to have an outbreak of Covid-19 than those that implemented masking mandates at the start of the school year. The researchers concluded that “lapses in universal masking contribute to COVID-19 outbreaks in school settings.” Id.

92) Another study looked at pediatric Covid-19 case rates in 520 counties, some with and some without a masking requirement. After accounting for factors such as age, race, pediatric vaccination rate, and rates of community transmission, it found that counties with school mask requirements had smaller increases in their rate of pediatric Covid-19 cases than those without those requirements. **Exhibit KKK.**

93) As stated above, universal masking can reduce the spread of the COVID-19 virus and protect those most at risk. Accordingly, numerous states have now instituted mask mandates, with the majority of other states having multiple school districts that now require masks. A copy of Today’s August 10, 2021 *State-by-state guide to school face mask mandates* is attached hereto as **Exhibit LLL.**

Dated: September 30, 2021



JOHANNE E. MORNE